Battered wife syndrome

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Battered wife syndrome is a symptom complex of physical and psychologic abuse of a woman by her husband. Although it may occur in up to 10% of Canadian women, it largely goes unrecognized. Such women often present with vague somatic complaints, such as headache, insomnia and abdominal pain. Thus, the diagnosis can usually only be made by asking nonthreatening open-ended questions. Most women remain with their husbands because they are afraid of them. Hence, successful treatment usually depends on the woman's leaving her husband and obtaining help in the development of a new self-concept.

Le syndrome des épouses battues est un groupe de symptômes de maltraitement physique et psychologique d'une femme par son mari. Bien que jusqu'à 10% des Canadiennes puissent en être victimes, il passe largement inaperçu. Les femmes battues consultent souvent leur médecin pour de vagues malaises somatiques tels que maux de tête, insomnie et douleur abdominale. Le diagnostic ne peut donc habituellement être établi qu'en posant à la patiente des questions non menaçantes qui mènent à la discussion. La plupart de ces femmes restent avec leur mari parce qu'elles le craignent. Donc, le succès du traitement nécessite habituellement que la femme quitte son mari et qu'elle obtienne l'aide nécessaire pour lui permettre de développer une nouvelle perception d'elle-même.

The family is the most frequent locus for interpersonal abuse ranging from verbal threats to murder. It has been estimated that 50% of Americans have experienced violence in their families.[1] Of all the murders in the United States 20% to 50% occur within families.[1] As well, the home appears to be an important "training ground" for violent behaviour: many individuals who witness violent parental interactions as children engage in physically abusive relationships as adults.[1] Yet violence within families is seldom recognized by outsiders, including physicians.

This article deals with one component of family violence, wife battering, and considers its relation to another component, child abuse.

The incidence of battered wife syndrome ranged from 1.15/1000 in Britain in 1975[2] to 1/10 in Canada in 1982.[3] This marked variation may be explained by geographic differences, differences in the definition and diagnostic criteria of battered wife syndrome, and the effect of the economic recession on family violence. An increase in all forms of family violence has been attributed to the economic recession, the assumption being that unemployed people tend to take out their frustrations on their families.

Battered wife syndrome has been defined as a symptom complex in which a woman has received deliberate and repeated (more than three times) demonstrable injury from her husband, the minimal injury being severe bruising.[4] This definition, however, is too specific since physical abuse may not produce severe bruising, and psychologic abuse is not considered. Women who are physically abused are also psychologically abused, and their recollections of the psychologic abuse are often more vivid and longer lasting than those of the physical abuse.[5] Therefore, the syndrome should be defined as a symptom complex of both physical (including sexual) and psychologic abuse of a woman by her husband. A husband includes any male with whom a woman has an intimate relationship.

There appear to be three distinct phases of violence in a relationship: that in which tension builds, that in which violence erupts and that in which tension is relieved. In the last phase the husband is often kind, loving and remorseful. This postviolence reconciliation often leaves the woman hopeful that her husband will change and reinforces her decision to continue the relationship. Therefore, she often appears unconcerned about the violence. Battered women usually present to their physicians towards the end of the first phase or during the last phase.

Legal history of wife battering

Wife beating has been sanctioned legally and socially throughout history. The word "family" is derived from the Latin *familia*, which in Roman culture connoted the group of slaves belonging to an individual.[6] As early as 753 BC married women were defined as necessary and inseparable possessions of their husbands.[2] The husband's authority to chastise his wife was explicitly written into English common law. Blackstone, in 1763, explained: "For, as he is to answer for her misbehaviours, the law thought it reasonable to entrust him with the power of restraining her by domestic chastisement."[2]

The husband's right to hit his wife was legalized in the United States in 1824, with the restriction that "he use a switch no bigger than his thumb".[7] This law was overturned in 1874, when the North Carolina courts ruled that "the husband has no right to chastise his wife under any circumstances".[7] Unfortunately, the courts qualified this statement by saying: "If no permanent injury has been inflicted, nor malice, cruelty nor dangerous violence shown by the husband, it is better to draw the curtain, shut out the public gaze, and leave the parties to forget and forgive."[7] In 1969, 20% of Americans approved of slapping one's wife.[8] Surprisingly, this figure increased with their income and education (e.g., to 25% among the college-educated).[8]

In Canada the physical abuse of a woman is now regarded as assault,

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but women have been reluctant to press charges. Of the women who stayed at Interval House (a shelter for battered women and their children) in Saskatoon in 1981–82 only 15% pressed charges or pursued a restraining order or peace bond against their husbands.[5] Similarly, the courts are reluctant to convict the assailants since the evidence is often circumstantial. In most Canadian cities peace officers cannot press charges unless they have witnessed the assault.

Profile of the abusive husband

An association has been noted between alcohol use and marital violence in all the studies of battered wife syndrome. Alcohol use preceded the violence in 93% of the cases in one series[1] and in 60% of the cases reported at Interval House.[5] Indeed, a wife abuser may become intoxicated to carry out a violent act,[9] thus "using" his intoxication to disavow or provide an excuse for his aggressive behaviour.[1]

Abusive husbands, as well as battered wives, were often subjected to a violent environment when they were children.[1] Thus, a woman may feel sorry for her husband because of his history of deprivation and abuse and often stays with him for this reason.[1]

When not being aggressive, wife abusers have been described as childlike, remorseful and yearning to be nurtured.[10] This picture of fragility was confirmed by occasional reports of a husband's suicidal or psychotic behaviour when his wife threatened to dissolve the relationship.[10] In these instances the marriage often becomes a life sentence for the wife.

In one study extreme jealousy was noted in 57 of 60 men who had abused their wives.[10] Many of them had refused to allow their wives to work, and others had tried to ensure that she worked at the same place as he did so that he could monitor her activities and relations with friends. This extraordinary possessiveness was also noted in another study, in which 66% of the husbands had accused their wives of infidelity or had monitored their activities.[11]

In many cases of battered wife syndrome, the husbands had also abused their children; this was true in 54% of the cases in one study[12] and in 25% of the cases in another.[5] Thus, the possibility of child abuse should be investigated in all cases of battered wife syndrome.

Profile of the battered wife

In most cases of battered wife syndrome the women had left home at an early age to escape violent, jealous and seductive fathers who kept their wives and daughters "imprisoned".[10] Marriage during the teenage years, often without a period of engagement,[12] was the usual means of escape. Many women later left their husbands, but they usually returned owing to their economic and emotional dependence on their husbands and the threat of violence. If they ended the relationship and established another one it was most likely with another wife batterer, in accord with the theory of "assortive mating".[12]

In their study of 60 cases of battered wife syndrome Hilberman and Munson[10] found that the women had a uniform psychologic response to violence. Agitation and anxiety bordering on panic were almost always present. They were apprehensive of imminent doom. Thus, any symbolic or actual sign of potential danger resulted in increased activity, agitation, pacing, screaming and crying. They remained vigilant, unable to relax or to sleep. When sleep did come, it was accompanied by nightmares of violence and danger.

In their dreams the women actively attempted to protect themselves; however, in reality they were passive and unable to act. They felt drained, fatigued and numb and had no energy to do more than the minimum in household chores or in looking after their children. They had a pervasive sense of hopelessness and despair about their lives. They saw themselves as incompetent, unworthy and unlovable and were ridden with guilt and shame. They thought they deserved the abuse, saw no options and felt powerless to make changes. Thus, a cycle of "learned helplessness" was established.

The use of neurotropic drugs is common among battered wives. In one study 71% of the women were taking antidepressants or tranquilizers, 46% of the women had sought a psychiatric opinion and 42% had made a suicide attempt or gesture.[13]

Although these studies suggest that there is a typical battered wife, such stereotyping is dangerous. We may feel that if a patient does not display these characteristics she is probably not a battered wife. However, while we should realize that these characteristics indicate a high risk of battered wife syndrome, we should not lose sight of the fact that wife battering is present in all socioeconomic classes. Every woman is a potential candidate.

Diagnosis

Physicians have a poor record of diagnosing battered wife syndrome. Among 60 cases in a general medical clinic the history of violence was known to the referring clinician in only 4,[10] although most of the women and their children had received ongoing medical care at the clinic. At Interval House in 1981–82 only 3 of 129 referrals came from physicians, the same number as from taxi drivers.[5]

The inability to diagnose the syndrome may be explained by the fact that the profile presented to the clinician is vague. The women visit their physicians often, usually with somatic or conversion symptoms or psychophysiologic reactions. Their most frequent complaints are headache, insomnia, a choking sensation, hyperventilation, gastrointestinal pain, chest pain, pelvic pain and back pain. They may also show signs of anxiety neurosis, depression, suicidal behaviour, drug abuse and noncompliance with medication.[14]

Most physicians respond to interpersonal violence with disinterest, blame or disbelief. They tend to stereotype the patient, blaming her for inviting the violence. Even if they suspect abuse some clinicians find it impossible to directly question the patient because her answers may be overwhelming, thus leaving them feeling as anguished or as helpless as the patient. Some clinicians may have experienced family violence as a victim or as a relative of a victim.[14]

The physician's primary role is to identify the syndrome. This can usually be done only with straightfor-

ward, nonthreatening open-ended questions to the patient; for example, "In what areas do you and your spouse experience conflict?" or "How does your spouse express anger?". The problem can often be detected by observing the nonverbal response, such as hesitation or a lack of eye contact, as well as the verbal response. The physician should then ask more specific questions, such as "Does your husband beat you?", "When was the last time?", "How often?" and "In what ways?". The patient should also be questioned about whether her children have been abused.

By incorporating nonthreatening questions into the routine functional inquiry the rate of detection of battered wife syndrome will be substantially increased. Once the diagnosis is made the patient should present to an interval or transition house. However, it is not always easy to persuade the patient to do so. I have often called Interval House myself and made arrangements for the patient and her children to go there. If they don't show up I am notified, and then I call the patient again. I have often been frustrated when patients say "Well, I'll think about it" or "I think we can work things out" or "I'll give it one more try". In this instance you can only reassure the patient that you're interested and willing to talk about the problem any time.

Treatment

In theory the aim of treatment of battered wife syndrome is to terminate the violence, not necessarily the marital relationship. In practice, however, the husband usually does not perceive his behaviour as a problem requiring intervention, and his wife remains secretive about any intervention to avoid further violence. Therefore, it is essential to move the woman and her children from the home to a safe environment. The combination of continuing threats and violence by the husband and the absence of provisions for safety are universally identified as deterrents to action. Battered women give many reasons or rationalizations for staying at home, but fear is the common denominator. It immobilizes them, ruling their actions, their decisions and their lives.[7]

When a woman comes to Interval House we first emphasize that she and her children are safe. Without such reassurance their fear makes further communication and education impossible. The second step is to educate the woman about battered wife syndrome. Through educational sessions she comes to realize that she is not alone and that the problem lies with her spouse, not with her. We try to build up her self-confidence, centering on the development of a new self-concept, from "victim" and "failure" to a competent, autonomous person.[15] The woman must come to define her own acts, accept responsibility for them and see herself as capable of acting independently. Once this stage is reached the woman is usually ready to return to the community. Assistance is provided in finding her accommodation and a job and, if necessary, in re-establishing her and her family in the community.

Battered women are more successful at reversing their helplessness when they leave their husbands than when they remain and try to change the relationship.[16] The husband's problems, such as alcoholism, must be treated, but his method of expressing anger is difficult to change. Ongoing "couples counselling" has had limited success.[16]

Case report

A 23-year-old registered nurse presented with a 6-month history of abdominal cramps and pelvic pain. Because the physical examination and routine laboratory investigations showed no abnormalities, a complete work-up, including radiologic studies of the gastrointestinal tract and gallbladder and pelvic ultrasonography, was performed. However, no abnormalities were detected. Spastic colon syndrome was diagnosed.

Over the next few months the patient continued to experience frequent acute episodes of abdominal pain. Only after many months was she asked about her relationship with her husband. At that point she quivered and started to cry. She described her husband as a "Dr. Jekyll and Mr. Hyde". Apparently all had been well until they were married. He had begun to beat her on their honeymoon. She had also had a similar relationship with her only other steady boyfriend before her marriage.

The beatings from her husband became progressively more frequent, as did the episodes of abdominal pain. I advised her to seek help through Interval House, but she refused, saying that she still loved her husband and didn't want to leave him. Three months later she presented with rather bizarre neurologic symptoms, including paresthesia, paralysis, syncope and headache. A complete neurologic evaluation, including electroencephalography and brain scanning, gave normal results. Her symptoms were diagnosed as a hysterical conversion reaction.

At the time of writing she was virtually incapacitated and was having regular episodes of the symptoms I have described. She was still refusing to seek help from Interval House.

Comments

This case illustrates a number of important features of battered wife syndrome. Most important, we must ask the question before we can expect an answer. This patient was not asked about her relationship with her husband as a routine part of the functional inquiry. Thus, diagnosis was delayed several months. Complaints of vague abdominal pain are probably second only to headache as presenting symptoms of the syndrome.[14] Most patients make several visits to their physician before the problem is discovered, if it is discovered at all. Also, the progression to more complex psychologic problems as demonstrated by this patient's conversion reaction is common.[1]

The description of the husband as a "Dr. Jekyll and Mr. Hyde" is well documented.[17] The patient would not seek help from friends or agencies since she felt no one would believe her. Indeed, battered women seldom accept assistance because they do not believe it will be effective.[17] This patient's previous boyfriend had also been a batterer, thus demonstrating the theory of assortive mating.[12]

Conclusions

Battered wife syndrome is much

more common than is recognized. The incidence may be as high as 1 per 10 Canadian women. The syndrome is usually not diagnosed because the right questions are not asked. Nonthreatening open-ended questions should be part of a routine functional inquiry. However, treatment is usually not effective if the patient remains with her husband. The most successful approach is to refer the patient to an interval or transition house for appropriate counselling that centres on the development of a new self-concept.

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